DOCUMENT RESUME

ED 035 707 UD 009 530

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TITLE It's Either Brain Damage or No Father: The False Issue of Deficit Vs. Difference Models of Afro-American Behavior.
PUB DATE Aug 69
NOTE 28p.; Paper presented in part at the Annual Convention of the American Psychological Association, Washington, D.C., September 1969

EDRS PRICE EDRS Price MF-$0.25 HC-$1.50
DESCRIPTORS *Biculturalism, *Black Community, Class Attitudes, *Community Health Services, Culture Conflict, *Guidance Counseling, Institutionalized (Persons), *Psychological Services, Retarded Children

ABSTRACT

The distorting notions of the deficit and different Afro-American subculture have led white psychologists and guidance counselors to diagnose incorrectly behavior aberrations in Black children. A case study of a Black child who was hastily diagnosed and institutionalized as brain damaged, retarded, and psychotic illustrates this point. A bicultural model, rather than the deficit oversimplified model, is a preferable conceptual framework. Educators and health specialists must not only recognize the legitimacy and creativity of ethnic subcultures, but also must recognize that Afro-Americans are already more conversant with and competent in the main stream culture than most non-Black Americans would realize. The bicultural conception calls attention to a kind of psychocultural adequacy in the Black community. Out of this could perhaps come the beginnings of a more realistic and humane basis for service institutions changing to provide for Afro-American needs and interests. (KG)

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IT'S EITHER BRAIN DAMAGE OR NO FATHER

The False Issue of Deficit Vs. Difference Models of Afro-American Behavior

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Prepared for Delivery, in part, at a Symposium, "Deficit or Difference: Negro Culture in the United States," American Psychological Association, Washington, D.C., 2 September 1969

August 1969

UD 009530

1. Theory and Current Research

Apparent themes of this symposium include the argument that a psychological deficit model or normative approach to Afro-Americans rules educational theory and practice, perpetuating both scientifically untenable beliefs and destructive institutional policies. Against this is placed the contention that a cultural difference model or relativistic anthropological approach, presently absent from the educational scene, should be fostered because it is scientifically more adequated and will produce more constructive results, especially for Afro-American children.

My own somewhat different view of these problems is derived in part from a current ethnographic study of poverty and Afro-American subcultures in a large northern city. This ongoing research, which has been in progress for nearly fourteen months, is being carried out by a family team consisting of myself, my wife, and our two-year-old son (Valentine and Valentine 1970a 1970b).[1]

My thesis is threefold: (1) both the deficit model and the difference formulation are already well established in ghetto educational theory and practice; (2) both models are in serious need of scientific revision; and (3) both are extremely pernicious as presently applied. Moreover, we are convinced that these same models are producing equally destructive results through the ghetto interventions of other mainstream institutions controlled by dominant social strata. Preeminent among these institutions are psychiatric clinics and hospitals. In all probability, however, the deficit and difference formulas are projected upon Afro-Americans by all major institutions of the wider society from the mass media to official anti-poverty programs. In other words, both models really belong to certain aspects of mainstream culture which impinge most directly on Afro-American ghetto communities.

Anthropological training and experience, plus more than a passing acquaintance with the psychological and sociological literature on Afro-Americans, convinc-

us that the deficit theory is largely undemonstrated. Any theory of class or racial deficits of biological origin is quite undemonstrable - indeed scientifically untestable - in an ethnically plural and structurally discriminatory society. The necessary separation of biological and socio-cultural factors is methodologically impossible in this setting. Writings which put forward biochemical genetic determination, or social selection in the evolutionary sense, as explanations for group differences in behavior must therefore be dismissed as pseudo-scientific nonsense.

On the other hand, environmentally imposed and biologically mediated group deficits can probably be demonstrated. Life in Black communities today (and no doubt among poor non-Blacks as well) presents one with much evidence that poverty and ghettoization subject the human organism to repeated biological assaults such as malnutrition, poisoning, and physical traumas from intrauterine life until death. These phenomena are structured by the social class system, but there is probably no social category which suffers more from them than Afro-Americans except perhaps American Indians. Long-term immersion in ghetto conditions leaves one vastly impressed with the amount of organic punishment human beings can absorb without crippling impairment.

The area in which the clearest choice can be made between deficit and difference formulations is the realm of cultural differences, researched by anthropologists and linguists and emphasized in this symposium. It is both untenable and unjust to characterize Afro-American culture patterns as merely deficient or pathological versions of mainstream American culture. Indeed, systematic research guided by hypotheses derived in part from a cultural-difference model may reveal unexpectedly rich ethnic variation. Our current field work in a single urban community has so far produced evidence of some fourteen different Afro-American sub-groups with more or less distinct subcultures, as well as nine other non-Afro ethnic subgroups.[2] These subcultures present distinctive group identities and

behavior patterns including languages and dialects, aesthetic styles, bodies of folklore, religious beliefs and practices, political allegiances, family structures, food and clothing preferences, and other contrasts derived from specific national or regional origins and unique ethnohistories. It would be absurd to describe any of these subcultural systems as differing from mainstream culture only in terms of insufficiency or deficit.

Nevertheless, a simple model of cultural difference is inadequate to clarify the cultural dynamics of this heterogeneous community. The notion of a single homogeneous "Negro culture," which is often conveyed by the difference model, will not fit our data except perhaps in certain special senses which await confirmation or disconfirmation as the research continues. Further study of the known subcultures may reveal intergroup commonalities that are referable to one or more of three derivations: (1) shared African cultural roots, (2) common influences from the intervening ethnohistory under European domination in the New World, and (3) an emergent Afro-American culture recently influenced by Black Nationalism as a revitalization movement. The last of these three conditions will probably be relatively easy to demonstrate. The other two appear more problematical at the present stage of our research. In any case, a model which portrays only something labelled "the Negro subculture" is clearly an oversimplification.

Another inadequacy of the difference model is that it neglects and obscures the important concept of biculturation. This concept was developed in American Indian studies (Polgar 1960) and seems to have made little impression on students of Afro-Americana until recently (cf. Hannerz 1969a, 1969b, 1969c). The essence of the biculturation process is that a human group is simultaneously enculturated or socialized in two different cultural systems. In our own thinking developed during the present research, this concept has been most helpful in clarifying the dynamic relationships and structural articulation between subcultures and the dominant mainstream culture of the whole society. We use biculturation to describe

how people learn and practice both mainstream culture and ethnic subcultures at the same time. Much intra-group socialization is conditioned by ethnically distinct experience, ranging from linguistic and other expressive patterns through exclusive associations like social clubs and political machines to the relatively few commercial products and mass media productions designed for ethnic markets. Yet at the same time, members of all subgroups are thoroughly enculturated in dominant culture patterns by mainstream institutions, including most of the content of the mass media, most products and advertising for mass marketing, the entire experience of public schooling, constant exposure to national fashions, holidays, and heroes. These sources constantly impinge on Afro-American homes which thereby share these enculturation experiences with mainstream America. We also find that Afro-Americans and other poor people receive a constant barrage of mainstream socialization in more specialized forms from other institutions which operate particularly, though not always exclusively, within poverty areas. These include the welfare system, the police-courts-prison complex, anti-poverty programs and other forms of petty political patronage, and various types of employment through which middle-and upper-class patterns are commonly communicated, such as domestic service.

To some extent, ethnic subcultural socialization is focused within family units and primary groups, with mainstream enculturation coming more from wider sources. However, this is by no means a sharp or consistent division of socializing influences. Ghetto homes expose their members from earliest childhood to many mainstream themes values, and role models. This occurs not only through behavior of parents and others which reflects mainstream as well as ethnic conditioning, but also through external agencies which constantly operate within most households, such as television. Moreover, Afro-American children typically begin, at least during the third year of life, to be exposed outside the home to such mainstream cultural settings as may be available to ghetto dwellers: movies, amusement parks,

children's programs of anti-poverty agencies, church activities, retail shopping, public health services, and others. Experience is thus so structured that Afro-Americans become thoroughly bicultural quite early in their lives.

For various reasons, much of the mainstream cultural content Afro-Americans learn remains more or less latent or potential rather than being actively expressed in everyday behavior. One reason is that the structural conditions of poverty, discrimination, and segregation prevent people from achieving many mainstream middle-class values, aspirations, and role models to which they nevertheless give psychologically deeprooted allegiance. Another reason is that some poor Blacks are acutely aware of the contradictions within mainstream culture and thoroughly schooled by experience in the seamier side of middle-class life. A certain number of Afro-Americans regard the everyday corruption of their White employers, political patrons, law-enforcement officers and others as immoral, and they consciously refuse to emulate them even though they are often under considerable pressure to do so.

Another common pattern of what we call passive enactment of mainstream culture occurs in settings of formalized intergroup contact. Examples include court and commission hearings in which the official personnel are generally middle-class Whites, the proceedings are formally conducted according to mainstream patterns including middle-class American English sometimes augmented by specialized vocabulary, and the defendants or complainants, or both, are Afro-Americans. Numerous observations have convinced us that generally the Black participants in such proceedings understand fully what is being done and said. Yet when called upon to speak they tend to confine themselves to Afro-American English dialects. Incidentally, this often leads to confusion, but it is almost invariably the middle-class Whites who misunderstand. The obvious reason for this is that the Afro-Americans are bicultural and bidialectical, whereas the non-Black mainstreamers are generally limited to a single cultural system. In other words, poor Afro-

Americans - far from being culturally deficient - often posses a demonstrably richer repertoire of varied life styles than their ethnically nondescript social superiors.

It should be clear that a cultural-difference model which emphasizes exotic subcultural patterns to the exclusion of biculturation will not fit our data. This limitation of the difference model, as presently constructed, is probably its fatal flaw. The basic difficulty is an implicit assumption that different cultural systems enter human experience only as mutually exclusive alternatives, never as simultaneously available repertoires of belief and behavior. This leads to a convergence between the difference model and the popular but discredited notions of a so-called "culture of poverty" or "lower-class culture" (cf Valentine, 1968, 1970). For example, one proponent of the difference model whose work is otherwise innovative stimulating, and persuasive has recently published the following remarks. He writes of

> A different culture . . .recurrent throughout the country in lower-class Negroes. And by lower class here I don't just mean poor; I mean a special culture configuration, what the anthropologist would call a 'different' culture. . .The lower-class Negro is certainly in many ways culturally quite different from general middle-class American society. . .
>
> When Africans came to the United States, they assimilated in part to the white culture but not entirely. African social patterns that were brought to the United States were modified by slavery, were partially conformed to white social patterns, but not entirely. There were innovations. . ., but they were not entirely identical to the white norm of behavior. . .
>
> The American Negro who hasn't been too much in contact with standard American culture. . .or too assimilated to it, often has a very different kind of family structure, and sometimes the kinship and family relationships are very foreign from any kind of European model. (Stewart 1967:59-60)

In this quotation we see that the convention of conceptualizing Afro-American culture in terms of acculturation - and especially assimilation - leads to ignoring the bicultural dynamic of Black community life in America. This assimilationist bias - and particularly its key assumption that cultures and subcultures are mutually exlusive or inevitably competitive alternatives - becomes

vitally important in a practical sense when it is passed on to certain audiences. These include professionals in such service areas as education or psychiatry. The author of the quotation is no doubt well aware of the qualifications which need to be added to his seemingly sweeping generalizations. However, the quoted passages were presented to a workshop of educators. One can hardly assume that such an audience will make the necessary qualifications on their own.

On the contrary, our present research leads us to believe strongly that most school teachers and other educational specialists working in ghetto schools have well established cognitive and affective sets into which such portrayals of cultural difference will fit perfectly. Moreover, this perceived consistency will reinforce a complex of attitudes and practices which are injurious to Afro-American pupils, regardless of the intentions of difference-model theorists. On dozens of occasions and in settings ranging from classrooms to counseling sessions to public confrontations with Afro-American parents and children, we have observed white educators expressing highly standardized beliefs and feelings about ghetto children and their families. Key items in this inventory include explicit statements that Afro-Americans are culturally different, that the cultural differences impede or prevent learning, that the school should function to wipe out these differences, but that educators frequently cannot succeed in this aim because the children are psychologically deficient as a result of their cultural difference. The attitude is that such children are "more to be pitied than scorned, but after all. . ." So the projections by educationists go on around in a self-justification of circular reasoning which rationalizes all the failures of ghetto schools by blaming them on the students and the parents. Particularly when the context is one of intergroup confrontation, it it quite clear that these beliefs are backed by very strong negative emotions which often amount to obvious race hatred and blatant class antagonism.

Of course, all this is superficially disguised by accompanying rhetoric

and rituals invoking liberal values, intergroup harmony, and dedication to upward mobility for the so-called "culturally deprived or disadvantaged." Partly because this humane-sounding camouflage is so well developed, it seems most doubtful that these educators will function more constructively after being further exposed to the difference model. On the contrary, we would predict that the respect for subcultural systems as legitimate human creations, which is communicated with the difference model, will be accorded no more than lip service. Meanwhile the descriptive and analytical core of the model will continue to be used as one more excuse for educational failure. It is in these senses that I put forward the thesis that both the deficit model and the difference formulation are already fully established in ghetto schools and that they both are applied to the serious detriment of Afro-American people young and old.

2. A Case History

Some illustrative data may now be cited to support the points made so far. Here my text comes from the response by a guidance counselor made publicly and in our presence, to a question from a long married Afro-American mother of 11 normal children. The mother had asked why children in our neighborhood public school so often fail to learn. The counselor replied, "We find that children in our school who don't learn either are brain-damaged or don't have a father in their home," and he expanded considerably on this theme. The counselor should have known the normal nature of this woman's household, for he had had a number of private interviews with the same lady, arising out of the fact that one of her sons had been doing poorly in the same school. Moreover, the same counselor has been quoted to us by several other community people as advancing the same formula on similar occasions. What is most significant about this example is that this man has the full backing of his school administration in his approach, and the attitudes he expresses are fully typical of his colleagues. In this widespread universe of discourse, "brain damage" is a code phrase for biological deficit, and "no father

in the home" is a euphemism for despised cultural differences.

Within this context, the case history of a former student at the same neighborhood school becomes relevant. This 8-year-old boy, presently a psychiatric patient, comes from an Afro-American family with roots in a rural seaboard region of the middle South and more recent residence in a port city of the upper South. Our understanding of this boy is based on information from the following sources. (1) Three months of daily observation of the patient's behavior in his present Northern urban home and community, including much contact with his foster family, other local relatives, playmates, and additional neighborhood associates. (2) Weekly or more frequent visits with the patient during a recent psychiatric hospitalization of 3½ months, including observation of most of his daily activities in the hospital. (3) A very full week of interviews and observations in the region of the patient's birth, including intensive contact with all 10 of his most significant surviving relatives, all members of his former foster family, all 14 medical, welfare, law-enforcement and correctional professionals who had important contact with the patient or his close relatives. At this time we also collected full medical, legal, police, and newspaper records from all sources known to be relevant. (4) Later we were also granted access to the records of the case in two Northern hospitals where the youngster became a psychiatric patient.

The findings from the retrospective evidence can be summarized briefly. All medical and family history data indicate a normal pregnancy and birth, followed by an organically normal early childhood: no serious fevers, no bad falls, no unconsciousness or other obviously pathogenic effects from the physical traumas which it will become clear the boy did receive. With one exception, no other member of the extended family has ever received psychiatric diagnosis or treatment. The exception is the patient's father who experienced a brief psychotic break several months after having been imprisoned for murdering the patient's mother. By the time we talked with this man in May, 1969, he had been returned to the

prison as normal, and our impressions accorded with this evaluation.

The boy's early childhood was dominated by an extremely hostile and punitive father and a very passive, indulgent mother. During this period the patient also spent much time in the poor but stable, warm, strict household of his maternal grandparents, spending many long visits there with his mother and his siblings. One of the father's chief impositions, evidentally based on intense sexual jealousy, was to keep his wife and children isolated from all other social contacts. Thus the boy had little or no direct experience of the outside world beyond his grandparent's home. Five of the patient's older and younger siblings have lived continuously in this same grandparental household in the South for the last 2-3 years. All of them appear to be normal and are reported doing well in school. All reliable evidence, including eye-witness testimony from the patient's older adolescent siblings, consistently indicates that the boy was not present when his mother died during his sixth year. Indeed he was shielded by the family from the knowledge of her death until circumstances, including the father's arrest for murder, made this impossible some two months later. On the other hand, the child certainly did both witness and receive many severe beatings from his father during the first 5½ years of his life. From early childhood on, this boy was regarded by all who knew him as decidely hyperactive, highly intelligent, somewhat aggressive and disobedient, but otherwise quite happily related to peers and to adults other than his father. No one in his various family and neighborhood settings regarded him as uncontrolable, and it never occurred to any know relative or associate to label him as mentally ill.

All available family and professional sources directly knowledgable as to the facts agree that this youngster made a happy adjustment to life in a Southern rural Afro-American foster home during the year following his mother's death. After the initial grief of bereavement, there is no indication of lasting behavioral change in family or neighborhood settings at any time during this year. During

this same period, however, the boy received his first exposure to larger social institutions. Here a pattern emerged which appears to represent the roots of the patient's later difficulties.As long as his early experiences with larger institutions were mediated by his guardians or other adults in the foster family, for example in regular church attendance, everything went smoothly. When the boy was exposed alone to impersonal, bureaucratic, mainstream institutional settings, on the other hand, problems arose immediately. The middle-class and generally White authority figures in these settings saw his hyperactivity and tendency to disobedience as disruptive and uncontrolable. Teachers in a summer Headstart program for pre-schoolers remember this child chiefly as one who would not sit still in his assigned seat and be quiet. When he was taken to a large hospital for minor surgery, he was sent home a day ahead of the post-operative schedule because the nurses could not make him stay in his bed or keep up with his whereabouts within the institution. These institutional problems did not disturb the warm relationships within the foster home. When we met the boy's former guardians some two years later, they were obviously hungry for news of him, spontaneously reminisced about what an appealing child he was, and asked if we could help them get him back.

We interpet this retrospective evidence in the following way. The child suffered considerable emotional deprivation and disturbance of primary object relations during his first 6 years. This deprivation was substantially compensated by healthy relationships in the grandparents' household and further reduced by nurturance in the first foster family. In this connection, it should be noted that within Afro-American subcultures there appear to be both a structural fact and a socially learned expectation that family attachments are quite diversified and flexible in comparison with the rather narrow and rigid focus on specific parent-figures which is the mainstream norm. (While we do not feel that we fully understand the psychodynamics of this subcultural pattern at the present stage of our research, we are gaining the impression that it functions quite positively in the settings of

variable household composition which often stem from economic fluctuations and other recurrent stresses of poverty and minority status.) During this period the boy was adjusted, quite within normal limits, to Afro-American family and micro-institutional settings. Here his rambunctious hyperactive style was easily tolerated and controled without difficulty whenever necessary by subcultural standards. Because of the family's social isolation during early years when biculturation normally begins, the child received very little preparation for mainstream macro-institutional settings. His behavior style was not tolerated in these settings. Yet there was neither any close personal relationship nor any subculturally appropriate approach available among the institutional personnel. Under these conditions the already delayed biculturation process again failed to function. So the mainstream educators and health specialists were unable to calm the youngster down or keep him under control within limits acceptable to them. In the patient's history to this point we find no evidence of psychosis, organic deficit, or other serious psychopathology.

We turn now to more current evidence. As we observed this boy during the first 3 months of the present year, he showed a continuation of previously noted trends. He was clearly hyperactive, notably aggressive, strongly but never uncontrolably disobedient, and warmly attached to his new urban Northern foster parents, who are also relatives with the the same southern Afro-American background. The boy was clearly capable of stable relationships with his neighborhood peers, successful in learning a new physical and social enivornment, and able to perform such organized activities as periodic work for small payments and participation in small neighborhood institutions like a locally modified cub scout troop.

Nevertheless, the boy was found by the local public school to be incapable of learning and dangerously uncontrollable. Teachers reported that he refused to obey them and that he disrupted classes with various kinds of outbursts, including fights with other youngsters. The same guidance counselor mentioned earlier was

called in and decided the boy was deeply disturbed by a tragically unstable family life. This man placed in the record the fatefully erroneous statement that the boy had seen his father murder his mother. Precisely what misunderstanding led to this error is unknown, for none of the patient's kinsmen or associates in the North were acquainted with the circumstances surrounding the mother's death. The boy himself never alleged to us or anyone we know in the community that he had witnessed a killing. Until our trip to the boy's former homes, the actual facts were unknown outside the Southern branch of the family and a small circle of professionals in the South. Nevertheless, this non-existant trauma was invoked as the source of deep psychopathology by every educator, psychiatrist, and social worker who subsequently dealt with the child. The counselor and the school principal contrived to have the boy excluded from school without the legally required suspension hearing. By this time the youngster had become a psychiatric out-patient at a nearby hospital. After interviews and tests, the hospital personnel recorded their diagnosis of childhood schizophrenia with mental retardation and probable organic damage. Tranquilizing medication was prescribed. After the expulsion from school, institutional interest in the case dropped away, and nothing further was done.

The boy then spent several months freely and successfully living the life of the ghetto streets each weekday, while his foster parents literally worked day and night at minimally remunerative jobs to support the whole family. Over a period of 2 years in the urban North, the child's adaptation to home and community settings has been well within tolerable limits as defined by his Afro-American foster-family and neighborhood associates. No one in these settings saw him as abnormal or impossible to control. Nevertheless, his relationship to home and community became decidedly stressful for obvious reasons as soon as he was excluded from school and defined by external authorities as mentally sick. Among other things, his guardians worried about his safety on the streets, and tried without success to get him back into school.

We first met this youngster after the school explusion and heard his story from him, his foster parents, and other neighbors. With the permission and encouragement of the guardians, we naively turned to local school and hospital personnel for clarification. Before we knew it, there was suddenly a move afoot at the nearby hospital to have this long-forgotten child involuntarily committed to a state mental hospital immediately. Although there had been no change in the boy's behavior or situation, the plan for commitment was justified by a psychiatrist on the grounds that the patient was an iminent danger to himself and everyone around him. Local community leadership became aware of this plan and prevented it from being carried out. As the compromise among local power centers worked out, the boy was temporarily hospitalized in another institution for so-called "independent" evaluation. It was soon clear that because of the interlocking professional associations of psychiatrists and others between the two institutions the alleged "independence" of the new evaluation was thoroughly compromised.

By anthropological hook or crook we gained access to the operations and records of the institution where our young friend was now confined. We soon discovered that hospital staff people at all levels felt extremely threatened because out of the circumstances surrounding this patient's admission, they had concocted an image of the researchers, and even of the little boy himself, as "civil rights agitators" out to expose the institution by accusing it of anti-Black discrimination. While this posed certain methodological problems for us, it made life for the little boy even more miserable than it would otherwise have been. Lower echelon staff in particular were openly hostile and punitive, to the extreme of confinement in a straight-jacket for hours at a time. During visits to our friend we found the same child we had known before, with two significant additions. First, it was obvious that the boy actively hated the conditions of enforced confinement. Second, he was so heavily influenced by what the hospital staff referred to as a "chemical straight-jacket" that often he acted like a zombie.

Despite much bureaucratic and professional resistance, we managed to interview and observe all hospital staff with major responsibilities in relation to this patient. We soon found that the staff had projected such destructive power onto this 8-year-old that they talked about him as if he were about to destroy the hospital by physically assaulting its personnel and creating general chaos throughout the institution. Next we found that the middle-class White upper-echelon staff so often misunderstood verbalizations by our young Afro-American friend that they added "speech pathology" to the many strikes against him which they had accepted from the earlier diagnosis by the psychiatrist who originally tried to have him put away in a state institution. The hospital personnel were very largely ignorant of the boy's life before his admission. What little information they had of this nature came from his earlier psychiatric record plus a family history composed by hospital social workers. Both these sources were filled with significant error and distortions.

Eventually two lengthy staff conferences were held to decide what to do with this troublesome patient. A clinical psychologist presented the finding that on the WISC our little friend scored a so-called "borderline IQ," but as soon as he was given a chance to learn the arcane secrets of the Benton Visual Retention Test he immediately demonstrated a capacity to learn rapidly. Findings reported from the Rorschach and other projective tests indicated what the psychologist described as good reality testing, normal intelligence, and no evidence of psychosis of any kind. The neurologist reported no hard signs of organic deficit and only such minor soft signs that she concluded significant organic pathology must be regarded as unproven.

In spite of all this, two senior psychiatrists insisted that the patient was certainly psychotic, probably brain-damaged, and evidently retarded. The more they insisted, the more the psychologist, neurologist, and lesser staff tended to reinteroret their findings along lines more in accord with the assertion of deep

pathology. At one point a suggestion was made that the patient's tranquilizing medication be reduced or discontinued to make possible psychological and neurological retests. This provoked a burly male recreation aid, who probably weighs four times as much as the patient, to almost beg that if the boy were taken off drugs he should be locked up in continuous isolation. The proceedings reached such irrational extremes that ordinary experiences described by the young patient, which we know by observation are perfectly real, were presented as evidence of hallucination. The outcome was perhaps even more illogical than the proceedings which led up to it. The patient was to be released to his foster parents with an expressed professional evaluation that he probably could not make it in the outside world and therefore would soon be back in the hospital. It was made clear that wherever this little boy went in the world of macro-institutions he would be followed by a certified record attesting that he is dangerously insane.

The child was indeed returned to his foster home a few weeks ago. Personnel of the releasing institution have conveyed to the foster parents a strong message that the child is irremediably pathological. An additional message from the same source is the threat that the alleged pathology will sooner or later get the foster parents into trouble which may lead to serious legal sanctions. As might be expected, the youngster's guardians are by now quite anxious and confused. Our sad expectation is that within weeks or months the boy will be confined to a state institution from which he may never escape.

Our interpretation of these recent and current data can be summarized as follows. The patient received another developmental setback in the object loss occasioned by his move from the first foster family to his present guardians' household. Fortunately these new parents are warm and responsible people who are devoted to the child's welfare. Beyond these individual characteristics, the culturally conditioned flexibility of Afro-American domestic relations is again relevant. For these and perhaps other reasons, the boy was able to adjust normally

to the family and neighborhood dimensions of his new situation. Associates and intimates in these settings have found him no more than mildly undersocialized or immature, sometimes a nuisance but nothing more.

Yet the earlier difficulties, stemming from circumstantially arrested biculturation, have increased to crisis proportions. The personnel of mainstream macro-institutions now regard this patient as essentially without internalized controls. For the same reasons as earlier, these mainstream caretakers have been unable to produce any improvement in the patient's behavior. Out of feelings ranging from anxiety over disruption of institutional routines, to fear of racial conflict and stereotyped aversions against ghetto people, these caretakers have projected upon this small child the image of a powerful monster threatening chaos. They have evidently concluded that such a menace must be restrained by custodial and punitive confinement, lest its destructive potential become even more frightening.

So the whole local mainstream educational and medical apparatus operated in such a way as to continue preventing crucial gaps in the child's socialization from being filled in. Today as he nears his 9th birthday, the boy remains illiterate and he is becoming accustomed to institutional failure and rejection. His guardians are nearing the end of their capacity to resist authoritarian mainstream pressure to give up and accept the official diagnosis which their own experience has never supported. Unless some new factor enters the situation, these conditions can be expected to injure or sever the remaining parental ties which presently offer the only hope that this boy might still grow up as a biculturally normal Afro-American. Starting with a relatively minor disability attributable to his family history, over the past three years the patient has been effectively prevented from achieving healthy biculturation by the very nature and workings of mainstream institutions. Despite the damage already done, we can still find no convincing evidence that the case supports findings of psychosis, organic pathology, or retardation other than

the institutionally induced illiteracy. Today the child still illustrates how tough the human organism is and how much it can take. Soon the self-fulfillment of mainstream prophecies, enshrined in both the deficit and difference models, may become irreversible and permanent.

3. Wider Implications

During the course of the case history just described, we had occasion to discuss the patient at length with nearly a dozen medical, clinical, and social work specialists directly or indirectly involved in the case. In fact, we provided them with all our evidence, discussed our interpretations of the data, and made several recommendations. These discussions revealed over and over again that the thinking of these professionals is ruled by highly standardized assumptions embodying both the difference and deficit models of Afro-American psychology. We attempted to stimulate their interest in cultural phenomena by presenting the difference model in much the way it is being presented at this symposium. The standard reply was, in essence, "Oh, yes of course, that's just the problem!" One senior psychiatrist went on to volunteer his considered calculation that within our community and adjacent ghettos there are 30,000 Black children who are just as sick as the patient described earlier. (This statistical opinion casts a depressing light on the question how large a universe of Afro-Americans is represented by our case history.) The implicit assumption evident in all these conversations is that Afro-American culture is not only distinct but pathogenic, thus neatly combining the deficit and difference theories. This is perhaps not surprising, considering the outpouring of both specialized and popular literature campaigning for just this point of view. (Even Black psychiatrists are gaining the limelight by portraying their own people as a pathological group (Grier and Cobbs 1968, cf. Valentine 1969)). What has impressed us, however, is the rigidity with which this view is held by relevant professionals and the strength of emotional commitment to it which one senses in such specialists. At no time in these conversations were we able to

detect any recognition that a mainstream institution might bear the slightest responsibility for the patient's problems, not even any interest in the question what effect the various schools and hospitals might have had. On the contrary, the ruling implicit assumption was that all sources of difficulty must lie within the family or the non-institutional community. In short, there was no hint that any of the institutions might have acted in any way other than just as they did.

To us who know the patient well in his home milieu of Afro-American subculture, he looks entirely different from the image that institutional specialists have of him. We know that he functions well in his own subcultural world. From this per spective, it seems obvious that, even after months in a punitive custodial institution, the child shows none of the dire pathology attributed to him. The significant professionals in the boy's case, however, have never even seen his home and have no direct experience of Black ghetto life whatever. These men make it clear that they regard themselves as experts on Black children. Yet they make it equally clear, usually without intending to, that they have no understanding of the child's cultural milieu - or even any real interest in it, beyond the derogatory stereotypes carried by the difference and deficit theories. One senor clinician admitted that we might well be right in our contention that the patient was functionally well adapted to his home evnironment. This doctor insisted, however, that what goes on in the home or community is totally irrelevant to the problems of diagnosis and disposition: medical diagnosis and therapy are determined strictly within the clinical setting without consideration of extraneous data from the outside world. Such institution-bound professionals have insulated themselves from any understanding of cultural factors, except again the stereotypes in the literature.

Both the theoretical significance and the policy implications of the case history described here now seem clear. This youngster's problems can be understood primarily as a mainstream institutional failure in the process of biculturation.

In spite of a stressful and deprived early childhood, the patient succeeded in adapting sufficiently well to his Afro-American subcultural environment. Now the macro-institutional problems are threatening his adaptation to his third Afro-American home and community. The failure of the macro-institutional settings has been manifold. Not only was it in these settings that the patient's difficulties first became evident, but these same institutions have been unable to do anything constructive about his problems. The prognosis appears to be that a basically healthy child will end up being forced into one or more of the delinquent, mentally sick, or functionally illiterate roles defined by the society's major institutions.

This is not to say that the initial home setting played no part in the etiology of this case. Without attempting any psychological analysis of the original parents, it is plain that the father actively inflicted, with the mother's passive complicity, a double disadvantage on their son. Not only was his early maturation compromised by emotional deprivation and injury, but his potential biculturation was initially arrested by parentally imposed or allowed isolation. Yet it is precisely such intra-family problems which the so-called "helping professions" of mainstream culture - social work, guidance counseling, clinical psychology, and psychiatry - are supposed to resolve or at least mitigate. In this case, a long series of these professionals, plus their colleagues in education and hospital management, have done nothing but make the boy's problems worse for so long that they are now the principal source of the present unhappy situation. One or two reasonably sensitive and humane teachers or clinicians, willing to assert themselves against institutional norms almost anywhere in this long sad story, could probably have changed the course of events decisively and averted the impending tragedy. Diligent study has not disclosed a single individual of this quality among all the professionals involved in the case.

The individual aspects of this case are quite enough to make anyone who knows or cares about the people involved both sad and angry. If one contemplates

the wider implications, however, one begins to appreciate the dimensions of our society's intergroup tragedy. Reflecting upon a powerful psychiatrist's clear implication that some 30,000 children in one part of a single American city should be treated as this child has been treated, the imagination recoils from the obvious inferences. It seems imperative to recognize that men capable of such projects cannot be made into humanitarians by preaching the difference model to them. When it is remembered that the cultural-difference theory has already been assimilated by these people and made to support their existing approach, the futility, or worse, of communicating with them about subcultural contrasts must be apparent.

The practical and policy implications of biculturation theory, at least with respect to Afro-American communities, are radical and stringent in each of the several senses of both terms. Much impairment of Afro-American personalities is directly traceable to the standard operations of mainstream institutions which inhibit or entirely block vital portions of the biculturation process. It therefore appears that no amount of dedication by Afro-Americans to mainstream ideals, and no extremes of assimilationist effort by Negroes, can make these institutions function to the advantage of Black people. The group-destructive tendencies of these settings are too deeply built in to be susceptibel to rational reform. Certainly nothing will be accomplished by trying to teach professionals respect for subcultural systems when all their other training and experience has already taught them to regard these same subcultures as impersonally pathogenic and personally threatening.

At least two alternatives remain. One is for Afro-Americans to avoid mainstream institutions,as far as possible, and build their own parallel organizations for social services of all kinds. This is essentially the Black Nationalist orientation. For reasons of the existing power relations within our society,

this is an approach fraught with problematical practical issues of its own. The other alternative is a radical alteration of the existing dominant institutions with respect to the values, attitudes, and interests which they serve. Nothing like this can be realistically expected short of revolutionary innovations in the national social structure as a whole. This obviously involves equally problematical practical issues and power questions. From these perspectives, everything depends upon the presently unknown potential strength of Black pride and Black power as cultural revitalization movements, the rebellion of American youth, and perhaps a few other national tendencies. It would appear to be in these quarters that some reason for hope may lie. Certainly it must be clear that the debate between deficit theorists and difference proponents is of no practical or humane significance. This debate should be confined within the ivied walls where privileged people can still play intellectual games without regard to the consequences for the unprivileged people outside the walls.

As is already clear, I believe a biculturation model is preferable to other formulations discussed here. This is not only because a bicultural theory more adequately represents Afro-American realities than the distorting notions of deficit or the oversimplified difference concept. Recognition of bicultural processes is also more congruent with desireable changes in the practice of service institutions operating in Black ghettos. It is important that educators and health specialists not only recognize the legitimacy and creativity of ethnic subcultures, but also appreciate that Afro-Americans are already more conversant with and competent in mainstream culture than most non-Black Americans believe or admit. Indeed the latter point is more likely to neutralize mainstream ethnocentri than a simple difference model. The bicultural conception calls attention to a kind of psychocultural adequacy which mainstream Americans can respect in spite of their ethnocentrism - if they will only accept its reality. Out of this could perhaps come the beginnings of a more realistic and humane basis for service

institutions changing to serve Afro-American needs and interests.

Finally, however, there must be a word of caution on the relationship between theoretical ideas and social action. Intensive immersion in ghetto life makes one tend to feel that expecting new concepts in psychology to alter the nitty-gritty practicalities of major institutions is a romantic form of philosophical idealism. Let us assume that good scientists who are also real humanitarians can achieve intellectual ascendancy for the difference model, the theory of bicultura-tion, or other better concepts. Let us even assume that this outlook dominates the training of a whole new breed of service professionals. What will happen when this new wave hits the bulwarks of established macro-insititutions in the ghetto? We must be prepared for at least three depressing possibilities. Some of the new caretakers will shortly have their idealism shattered against the established stone walls and openly revert to the rationalizations of old hands. A second group may slip into a cynical hypocrisy in which the new ideals are given lip-service but the practitioner acts on his realization that bureaucratized professionals are rewarded for following existing institutionalized routines. Perhaps the remaining group will simply compartmentalize their theoretical training in a separate section of their consciousness from the practical exigencies of institutional practice. These possibilities seem all too plausible, unless the assumed conceptual changes are accompanied by radical shifts in power relationships and other factors conditioning the present functions of dominant institutions in the context of the class system and race.

There are many discouraging precedents and analogies to support these prognostications, and worse. Consider, for example, the implications of the following quotation from a recent paper advocating the difference model discussed in this symposium.

> In conclusion, we are hoping for a complete reevaluation of the assumptive base of most of the literature on the Afro-American. . . .We wish us as a profession and a society, not to seek integration, nor separation, but "acculturation. Acculturation which does not seek to destroy the ties

> that bind black Americans together. We wish to recognize that acculturation is a two-way street - that we, the white society, have something to learn from the black community and that we, too, can change as a result of those learnings. (Baratz 1968)

This quotation expresses well the anthropologically fostered doctrine of respect for worldwide cultural variety outside our own society, which has been absorbed by two generations of liberally educated Americans. The concept of acculturation itself describes the influence of dominant European societies on non-Western peoples through the impositions of colonialism. The one outstanding presentday outcome of these historical processes is the war in Vietnam. The American participation in this war is being administered by the very Americans who have been steeped in the liberal tradition of respect for foreign cultures. Nevertheless, the war is destroying Vietnamese society and culture. There are today many intimations of an internal Vietnam within the United States. If the internal war lasts long enough, perhaps it will be administered by White Americans who have gained from the difference model a new appreciation for the culture of their adversaries. Will they be any less likely to destroy that culture or those who live by it?

Footnotes

1. This research has been supported in part by P.H.S. research grant MH 16866-01 from a division of the National Institute of Mental Health.

2. I. Afro-Americans

A. Afro-English speakers.

1. Northern-urban U.S. Blacks

2. Southern-rural U.S. Blacks

3. Anglo-African West Indians

4. Guyanese

5. Surinam Takitaki-speakers

*6. West Africans

B. Afro-French speakers

7. Hatian Creole-speakers

*8. Other French West Indians

*9. French Guianans

*10. Louisiana Creoles

C. Afro-Spanish speakers

11. Black Cubans

12. A-B-C Islander Papiamento-speakers

*13. Panamanians

*14. Black South Americans

II. Hispano-Americans

A. Spanish-speakers

1. Puerto Ricans

*2. Central & South Americans

B. Portugese-speakers

*3. Brazilians

III. Asian-Americans

A. Arabic-speakers

4. Yemenites

B. Chinese-speakers

5. South Chinese

IV. Euro-Americans

A. British-derived English speakers

6. "Americans"

B. Jewish-Americans

7. Eastern Europeans

C. Romance-speakers

8. Italians

D. Others

9. Scandinavians

*Groups we have heard about but not yet observed.

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